Walgreens
Healthcare Plus

1 1 8

REGISTRATION & PRESCRIPTION ORDER FORM

MEMBER INFORMATION

Primary Cardholder Name: _____
First Middle Initial Last

Address: _____
Street (do not use P.O. Box) Suite or Apt # City State Zip

( ) _____ ( ) _____
Daytime Phone Evening Phone

Date of Birth: __ / __ / ____
MM DD YYYY

Female: ☐ Male: ☐ Email Address: _____
Optional

Doctor's Name: _____
First Last

Dr.'s Phone: ( ) _____

☐ Snap-on caps needed for this patient.

Allergies:
☐ 32-Codeine ☐ 87-Sulfa ☐ 70-Penicillin ☐ 93-Tetracycline ☐ No known allergies
☐ Other (list): _____

Health Conditions:
☐ 200-Diabetes ☐ 300-Hypertension ☐ 400-Heart Disease ☐ 500-Glaucoma
☐ 600-Stomach Disorders ☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ No known health conditions
☐ Other (list): _____

EMPLOYER AND INSURANCE INFORMATION

Employer Name: _____ ☐ Active ☐ Retiree

Insurance Name: _____

Member ID Number: _____

Group Number: _____

Please Note: By submitting this form, you have authorized release of all information to Walgreens Healthcare Plus (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan. Thank you for your order.
Please allow two weeks for delivery.

Please complete both pages ➙

1 1 9

DEPENDENT INFORMATION (Print additional pages if you have coverage for multiple dependents)

Dependent Name: _____
First Middle Initial Last

Address: _____
Street (do not use P.O. Box) Suite or Apt # City State Zip

( ) Daytime Phone ( ) Evening Phone

Date of Birth: / / MM DD YYYY

Female: ☐ Male: ☐ Email Address: _____
Optional

Doctor's Name: _____
First Last

Dr.'s Phone: ( ) Relationship to cardholder: _____

☐ Snap-on caps needed for this patient.

Allergies:
☐ 32-Codeine ☐ 87-Sulfa ☐ 70-Penicillin ☐ 93-Tetracycline ☐ No known allergies
☐ Other (list): _____

Health Conditions:
☐ 200-Diabetes ☐ 300-Hypertension ☐ 400-Heart Disease ☐ 500-Glaucoma
☐ 600-Stomach Disorders ☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ No known health conditions
☐ Other (list): _____

CREDIT CARD INFORMATION

Credit Card Number:
(Visa, MasterCard, Discover)

Credit Card Number:
(American Express)

Name as it appears on card: _____
First Middle Initial Last

Expiration Date: / / MM DD YYYY Signature: _____

It is standard pharmacy practice to substitute generic equivalents for brand drugs whenever possible. You will receive generic substitutes whenever possible, unless your physician will not allow a generic substitute, or you specify otherwise on the order form.

☐ By checking this box, I elect to receive brand drugs for all prescriptions in this order whenever possible. By making this choice, I understand that under my benefit plan, I may be responsible for the higher copayment and/or the difference between the brand and generic price of each drug.

Simply mail your original prescription and this form along with your credit card information to:
Walgreens Healthcare Plus, P.O. Box 29061, Phoenix, AZ 85038-9061, 1-800-345-1985